NYS DEPARTMENT OF HEALTH
HIV UNINSURED CARE PROGRAMS APPLICATION

Side 1

Received by:
Initials _____
Date ___/___/___

Please check the box for the program(s) you are applying to:

[ ] AIDS DRUG ASSISTANCE PROGRAM (ADAP)
[ ] ADAP PLUS (Primary Care)
[ ] HIV HOME CARE PROGRAM

Last Name	First Name	MI	Sex
			Female____ Male____ Transgender____

AKA or Other Name Used | Social Security Number | Date of Birth:

	| | | | | | | | |	/ /

c/o Name (If applicable)

Street Address (Proof Required) | Apt. # | Telephone (day) ( ) -

Telephone (evening) ( ) -

City | State | Zip Code (9 digits required) | County

Marital Status

Married living together [ ] Married living apart [ ] Single, widowed, divorced [ ]

Race

White [ ] Native American [ ]
Black [ ] Other (specify) [ ]
Asian [ ] Pacific Islander [ ]

Ethnicity

Hispanic: Yes [ ] No [ ]
Other _____

Language

Do you speak English? _____
If no, what language do you speak:

Medicaid: Have you applied? [ ] Yes [ ] No If "Yes," status: Denied [ ] Approved [ ] Pending [ ]

Medicaid#_____ Spenddown Amount $_____

Health Insurance Information/Prescription Coverage - Please enclose a copy of the Insurance Benefits Book

Do you have health insurance, retirement, HMO or another plan that pays for prescription drugs? Yes [ ] No [ ]

Company Name _____

Group Policy # _____ Your Policy # _____

Company Address:

Street | City | State | Zip | Phone#

Health Insurance Information/Medical Care Coverage - Please enclose a copy of the Insurance Benefits Book

Do you have health insurance, retirement, HMO or another plan that pays for your medical care? (check one)

Private Insurance (Not Health Maintenance Organization) [ ]
Health Maintenance Organization [ ]
Other Public Program [ ]
Medicare [ ]
Self/pay - Uninsured [ ]
None [ ]
Uninsured/unable to pay [ ]

Company Name _____

Group Policy # _____ Your Policy # _____

Company Address:

Street | City | State | Zip | Phone#

Living Arrangement

Live alone [ ]
Live with spouse or significant other [ ]
Live with parent or guardian [ ]
Live with nonrelatives who share expenses and/or care [ ]
Live with other nonrelatives [ ]
Live with children who receive assistance or support from client [ ]
Live with relatives other than spouse, children or parents [ ]
Homeless [ ]

Household Members

	Last Name	First Name	Sex	Date of Birth	Relationship
1					
2					
3					
4					

How did you find out about the Programs?

Doctor [ ] Friend [ ] Social Worker [ ] Community Organization _____ HIV Test Site [ ]

Poster [ ] Brochure [ ] Radio [ ] TV [ ] Newspaper [ ] Pharmacy [ ] Other _____

Pharmacy of Choice: _____ **Phone#**_____

NYS DEPARTMENT OF HEALTH - HIV UNINSURED CARE PROGRAMS

Name _____

Employment Status

Full Time (35 or more hours per week) [ ] Not employed and not disabled [ ]

Part Time (less than 35 hours per week) [ ] Medically unable to work [ ]

Income (Proof Required) Type	Applicant Gross Income	How Often	Household Member(s) Gross Income	How Often
Salary/Wages				
Interest/Dividends/Royalties				
Alimony/Child Support				
Rental Income				
Benefits				
Public Assistance				
Unemployment				
Veterans				
Social Security				
SSI				
Pension				
Other Benefits _____				
Disability				
Social Security				
Worker's Compensation				
Other Disability _____				
Other Income _____				

Liquid Assets Type	Applicant Balance/Value	Household Member(s) Balance/Value
Savings/Certificate of Deposit		
Checking		
Stocks/Bonds/Mutual Funds		
Pre-Tax Savings (IRA, Keogh, etc.)		
Other _____		

Is there anyone else in the household who is HIV/AIDS infected? If yes, please indicate how many. _____ (Optional)

Alternate Contact Person - Optional

I authorize the Programs to speak to the following person or persons about my application. (i.e. - Social Worker, Lawyer, Family Member or Friend)

Name	Phone Number	Relationship
1.		
2.		

Certification Statement

I certify that all the above information is true and correct and that I am a New York State resident. I understand the following:

- This information is being given in connection with the receipt of federal funds by the State of New York.
- Program officials may verify the information on this form.
- Program officials may periodically verify my Medicaid status and bill Medicaid as necessary.
- If I deliberately misrepresent information on my application I may be required to repay benefits under the Programs, and I may be prosecuted under applicable state and federal statutes.
- I hereby apply for benefits under the Uninsured Care Program and consent for my information to be used and disclosed as necessary for the purposes of my treatment, for payment for health care services and for the healthcare operations of the Program.

_____ _____

Signature of Applicant (or legal guardian if applicant is a minor) **Date**

All information submitted is confidential and will be used for the Programs purposes only.

Return this application and proof of residency, income and assets to:

ADAP, Empire Station, P.O. Box 2052, Albany, New York 12220-0052

If you need help filling out this application please call: 1-800-542-2437

DOH-2794 (6/03) **Return Copy of completed application requested: Yes [ ] No [ ]**